Town of Uxbridge
Health Plans Overview - 7/1/2021

Tufts Health Plans						
Benefits	**Tufts Custom Your Choice 2-Tier HMO**	**Tufts POS Plan**		****Tufts Advantage PPO**		**Tufts HMO Saver**
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	
Office Visit	*$0/20/20	$0/5/5	Ded then 20%	$0/Ded then $15	Ded then 20%	Ded then $0
Retail Prescriptions	$10/20/35	$10/20/35	Not covered	$15/30/50	Not covered	Ded then $10/20/30
Mail Order Prescriptions	$10/20/35	$10/20/35	Not covered	$30/60/150	Not covered	Ded then $20/40/70
Emergency Room	*$100 Copay	$25 Copay		$150 Copay		Ded then $0
Lab, Xray, Diagnostics	*Tier 1: Ded then $0 Tier 2: Ded then $35	$0	Ded then 20%	Ded then $0	Ded then 20%	Ded then $0
Imaging (CT,PET,MRI)	*Tier 1: Ded then $0 Tier 2: Ded then $450	$0	Ded then 20%	Ded then $0	Ded then 20%	Ded then $0
Inpatient Hospital	*Tier 1: Ded then $0 Tier 2: Ded then $1000	$0	Ded then 20%	Ded then $0	Ded then 20%	Ded then $0
Outpatient	*Tier 1: Ded then $0 Tier 2: Ded then $1000	$0	Ded then 20%	Ded then $0	Ded then 20%	Ded then $0
Chiropractic	*$20 Copay	$5	Ded then 20%	Ded then $15	Ded then 20%	Ded then $0
Deductible	*$1000/2000	$0	$250/500	$1000/2000		$3000/6000
Individual Rate	**$702.88**	**$1,013.20**		**$1,650.59**		**$576.87**
Family Rate	**$1,843.57**	**$2,658.15**		**$3,460.09**		**$1,513.07**

*** Deductible and Copay Funding Same As 2020**

**** PPO Availaible Only to Out-of-Area Employees**

Altus Dental Plan	
Benefits	**Altus Dental**
Type I - Preventative	100%
Type II - Basic	80%
Type III - Major	50%
Orthodontia	n/a
Deductible	
Type II or III	$50/150
Annual Maximum	$1,500
Individual Rate	**$43.97**
Family Rate	**$112.65**

VSP Vision Plan	
Benefits	**VSP Standard Plan B**
Exam Copay	$10
Lens Copay	$25
Frames / Elective Contact Allowance	$130
Frequency (exam/lenses/frames	12/12/24
Individual Rate	**$7.52**
Family Rate	**$16.18**